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ABSTRACT

The guidelines address implementation of related services (adapted physical education, occupational therapy, and physical therapy) in Colorado special education programs. The first section considers factors in organizing services: the legal mandate of P.L. 94-142, the Education for All Handicapped Children Act; characteristics and professional criteria of the three related services; models for service provision; and options for obtaining services. Section 2, on service delivery, examines identification, assessment, development and implementation of the individualized education program, and reassessment. Monitoring services is the focus of the final section, with information on administrative, professional, and state department monitoring. (CL)

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Adapted Physical Education, Occupational Therapy and Physical Therapy in Special Education Programs in Colorado

Guidelines for Implementation

June, 1979

Prepared by a Task Force

for

The Special Education Services Unit
Colorado Department of Education

Coordinated by

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U. S. Department of Health, Education and Welfare
Office of Education
Bureau of Education for the Handicapped

Adapted Physical Education, Occupational Therapy, and Physical Therapy in Special Education Programs in Colorado: Guidelines for Implementation

INTRODUCTION

State and federal regulations mandate the provision of special education and related services to all handicapped children in the public schools consistent with each child's Individualized Education Program (IEP). Physical education, regular or adapted for special needs, is an education service which is to be provided to all children. Related services are selected based on individual needs and include, among other services, occupational therapy and physical therapy.

Handicapped children in every school district have special problems and needs in the areas of motor performance, physical function, and physical independence. Professionals in adapted physical education, occupational therapy and physical therapy have unique training and abilities to assist these children to gain maximum benefit from their education program.

These services, and all other services, can be provided to handicapped students only at the specific recommendation of the IEP team. This planning team may include special educators, regular educators, parents, administrators, diagnostic personnel, therapists, the child (if appropriate), and other individuals. Professionals whose training and experience are medically related must help plan for and work with handicapped children in schools from an educational perspective.

This manual is designed to help those who administer programs for handicapped students to most efficiently and effectively utilize the resources that can be provided by professionals from adapted physical education, occupational therapy and physical therapy. The objective of the task force which conceptualized and wrote the contents of this manual was:

> TO SYSTEMATICALLY INTEGRATE adapted physical education, occupational therapy and physical therapy services given the requirement to provide individualized special and related services to meet the educational needs of handicapped children.

As professionals from these three disciplines gain experience in integrating their services into programs for individual handicapped children, they may be able to more specifically define areas where services from the three disciplines overlap, and where role specialization defines unique services.

The related services that may be required by handicapped children to assist them in benefiting from special education extend beyond those covered here. It is the hope of the task force that this manual will serve as a guide for those from other disciplines who wish to delineate structured methods for integrating their services into the individualized education programs of handicapped children who require such services to benefit from special education. It is an additional hope that these guidelines be looked upon as a place from which to begin and a direction in which to move with regard to the provision of services by occupational therapists, physical therapists, and adapted physical education teachers.

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SECTION I: Organizing Services

A. LEGAL MANDATE

Adapted physical education, occupational therapy and physical therapy have long been accepted as services which can benefit handicapped children and are in some cases considered an essential part of a child's educational program. The State of Colorado, through its Handicapped Children's Educational Act, recognizes the value of these services and designates adapted physical education teachers, occupational therapists and physical therapists as reimbursable professionals.

Public Law 94-142 requires that "free appropriate public education be provided to all handicapped children." A "free appropriate public education" is defined in that law as meaning both special education and "related services" (Reg. 121a.4).

The Rules and Regulations for P.L. 94-142 define special education, physical education and related services as follows:

> Special Education. (a)(1) As used in this part, the term "special education" means specially designed instruction, at no cost to the parent, to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions . . . . (121a.14).
>
> Physical Education. (a) General. Physical education services, specially designed if necessary, must be made available to every handicapped child receiving a free appropriate public education.
> (b) Regular physical education. Each handicapped child must be afforded the opportunity to participate in the regular education program available to non-handicapped children unless:
> (1) The child is enrolled full time in a separate facility; or
> (2) The child needs specially designed physical education, as prescribed in the child's individualized education program.
> (c) Special physical education. If specially designed physical education is prescribed in a child's individualized education program, the public agency responsible for the education of that child shall provide the services directly, or make arrangements for it to be provided through other public or private programs.
> (d) Education in separate facilities. The public agency responsible for the education of a handicapped child who is enrolled in a separate facility shall insure that the child receives appropriate physical education services in compliance with paragraphs (a) and (c) of this section. (121a.307)

SECTION I:
Organizing
Services

> Related Services . . . . transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education, and includes speech pathology and audiology, psychological services, physical and occupational therapy, recreation, early identification and assessment of disabilities in children, counseling services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training . . .
>
> (5) "Occupational therapy" includes:
> (i) Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
> (ii) Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
> (iii) Preventing, through early intervention, initial or further impairment or loss of function.
>
> (7) "Physical therapy" means services provided by a qualified physical therapist.
>
> Each related service defined under this part may include appropriate administrative and supervisory activities that are necessary for program planning, management, and evaluation . . . . (121a.13).

Further, the regulations go on to say that an individualized education program (IEP) must be written for each child, including among other items . . .

> A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular education programs. (121a.346)

The current interpretation of this regulation by the Bureau of Education for the Handicapped is that all needed related services should be specified in the IEP. Thus, occupational and physical therapy services may have to be integrated with the current system of educational services based on student need.

B. CHARACTERISTICS & PROFESSIONAL CRITERIA

1. *ADAPTED PHYSICAL EDUCATION*

a. Definition/Rationale

Adapted physical education is a diversified instructional program in which developmental and remedial motor skills, games, sports, rhythms and leisure activites are taught.

This instructional program is designed to meet the specific, individual needs of each student who, because of certain disabilities, may not be able to successfully participate in regular physical education programs.

b. Professional Criteria

The person providing adapted physical education services should have a four-year degree in physical education including teacher certification. In addition to teacher certification in physical education, this individual should have at least two semester hours (three quarter hours) in special education and two semester hours (three quarter hours) in adapted physical education.

It is strongly recommended that any individual employed to provide direct services and/or consultant services in adapted physical education have at least 12 semester hours (18 quarter hours) in special education and adapted physical education.

2. *OCCUPATIONAL THERAPY*

a. Definition Rationale

Occupational therapy is the application of purposeful, goal-directed activity in the evaluation, problem identification, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, in order to achieve optimum functioning and to prevent disability.

The occupational therapist provides services with a developmental and medical orientation or foundation in coordination with the educational team to help the student fulfill educational needs.

Specific occupational therapy services may include evaluation and training in the areas of fine motor, gross motor, perceptual motor and social/emotional development. Also, services may be provided in activities of daily living, preparation for vocational evaluation and training and adaptation of equipment and the physical environment.

b. Professional Criteria

The occupational therapist must be a graduate of an accredited program in occupational therapy. The occupational therapist must have completed six to nine months of supervised fieldwork with pediatric fieldwork preferred.

Following completion of course and clinical work, the therapist must pass a national certification examination to be designated a registered occupational therapist (OTR). If the occupational therapist is employed by a school district, a Type E certificate should be held.

3. *PHYSICAL THERAPY*

a. Definition/Rationale

Physical therapy as a profession is directed toward preventing or minimizing disability, relieving pain, developing, improving or restoring motor function, controlling postural deviations and establishing and maintaining maximum performance within the individual's capabilities.

Relating to services within education, the physical therapist works to develop and maintain the physical potential of a handicapped individual for maximum independence and participation in daily classroom and other educational activities which may be required for learning.

b. Professional Criteria

The physical therapist shall have satisfactorily completed an accredited physical therapy program.

The physical therapist shall be licensed to practice physical therapy in the State of Colorado by the State Regulatory Agency. If the physical therapist is directly employed by a school district, a Type E certificate should be held.

It is desirable for physical therapists working in educational environments to have pediatric experience, evidence of continuing education related to children with special needs, additional coursework in education and experience in multidisciplinary settings.

C. MODELS FOR SERVICE PROVISION

Two models for providing Adapted Physical Education, Occupational Therapy and Physical Therapy services are the center-based model and the itinerant model:

Center-Based: When several children who could benefit from services are located in geographical proximity, a specific site could be developed. Children needing services would be transported to the center. A center may be organized for several schools (or districts) or for one school (a resource room concept).

Itinerant: When children needing services are widely scattered throughout a geographical area, professionals travel to the children to deliver services.

Professionals who are full-time employees of school districts can provide these services, as can professionals who contract with districts from the community (e.g., from rehabilitation agencies, private practices, clinics, hospitals, etc.). In either model, both direct and consultative services may be appropriate. Direct services can be provided to children and consultative services can be provided to parents and to school staff.

D. OBTAINING SERVICES

The special education administrator has several options for securing adapted physical education, occupational therapy, or physical therapy services.

Adapted physical education services may be secured 1) through employment of a full-time specialty teacher to work exclusively with special education children, or 2) by a regular physical education teacher who has training and experience with adapted physical education and who may be assigned to work with individuals or groups of special education pupils one or more class periods daily.

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Services

Occupational therapists or physical therapists may be directly employed by school districts or contracted through Boards of Cooperative Services, private hospitals, rehabilitation facilities or from private practice. If the services of an occupational or physical therapist are obtained through private sources, the personnel providing the services must first be approved by the Colorado Department of Education before reimbursement for those services will be made available.

SECTION II: Delivering Services

The adapted physical education teacher, occupational therapist and physical therapist share many commonalities in their professional roles and concerns. One primary distinction is that physical education is an educational service mandated for handicapped children, with adapted physical education being provided when the child's condition necessitates. Occupational therapists and physical therapists have medically based training and experience; their services are mandated only if "required for the handicapped child to benefit from special education" (emphasis added). The child having a severe handicap, in need of detailed, in-depth assessment and probably direct treatment, is likely to require occupational therapy and/or physical therapy in addition to adapted physical education.

Administrators and parents often ask questions regarding the explicitly different responsibilities of these three professionals; e.g., 1) Do professionals from the three disciplines provide duplicate services? or 2) Could an administrative unit employ or contract with only one of the three professionals to adequately serve handicapped children? While all three professions are involved with remedial motor programs, the adapted physical education teacher usually works on a skill level designed to achieve success in adapted sports and games. In many instances, the well trained, experienced pediatric occupational therapist and physical therapist can offer overlapping services in the school environment. Both the occupational therapist and the physical therapist can provide direct services in the areas of gross motor, fine motor, perceptual motor, activities of daily living, and adapting the environment. The physical therapist generally has additional expertise in posture, e.g., scoliosis, lordosis, gait training, cardiorespiratory problems, joint mobility (overcoming contractures), and improvement of individual muscle strength. The occupational therapist has additional expertise in fine motor, perceptual motor, and certain areas of activities for daily living, i.e., feeding, dressing, hygiene, and preparing for homemaking skills and vocational skills.

Adapted physical education deals with all children who need special physical education intervention. These children may also be receiving physical and/or occupational therapy. It is essential that the personnel supplying the services coordinate their activities to the maximum benefit of the child.

The following example may illustrate how the three roles could be differentiated: A seven-year-old boy is diagnosed as having cerebral palsy (spastic hemiplegia) with accompanying mental retardation. The boy is enrolled in a class for significantly limited intellectual capacity (SLIC).

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Services

Physical therapy might include neurodevelopmental techniques to improve postural stability, range of motion, and strengthening exercises to affected side and gait training.

Occupational therapy might provide an evaluation of the child's fine motor development and provide therapy and activities to allow him to use both hands in school activities.

Adapted physical education might include instructional activities in small groups of children in developing skills and using adapted games which allow the boy to successfully participate within the constraints of his disability.

It is essential that appropriate medical information be available to all three professionals as part of the assessment procedure. Particular emphasis should be placed on securing information about a child's medications and about specific precautions to observe in working with the child. Additionally, Colorado Department of Education's Rules for the Administration of the Handicapped Children's Educational Act (1976) state:

7:03 Support Services

7:03 (3) When physical and/or occupational therapy is provided, it shall be in accord with the diagnosis and recommendation of a licensed physician.

A. IDENTIFICATION

---

1. Screening:

Screening may be described as: 1) a process of surveying large numbers of children in an effort to identify those having previously undetected problems; and 2) a process of reviewing written or verbal information concerning a child in order to determine the need for assessment. Adapted physical education teachers, occupational therapists and physical therapists may be involved in direct screening as appropriate, or indirectly as consultants to school personnel who regularly screen students.

2. Referral conference:

Prior to the initiation of formal assessment procedures, a referral conference is conducted. Participants at this conference may be the parent, the building administrator, a school psychologist, and the child's teacher. In consultation with the parent it is determined whether further assessments are necessary to determine a handicapping condition. As part of

this procedure, the adapted physical education teacher, the physical therapist and/or the occupational therapist may be called upon to provide assessment information in their areas of specialization.

3. Referral:

Children may be referred for assessment to the adapted physical education teacher, occupational therapist or physical therapist either before the child is enrolled in a special education program or at any time after his/her inclusion in a program if the child's condition warrants referral. Referrals may be made by educational staff members, support staff members, parents, physicians or community agencies. The follow-up of any referral made should be accomplished with strict attention to the procedural safeguards outlined in the state and federal statutes. The decision to deliver services to the child following the assessment should be made by the staffing committee on the basis of assessment findings. To assure that all children needing services are assessed and yet to guard against overassessment, the referral conference committee and/or the staffing committee should keep in mind the seriousness of the child's condition and the ability of other professionals to perform the assessment.

The following characteristics may be used by teachers and others as guidelines for referring a child for assessment. Multidisciplinary assessment procedures will determine the appropriateness of intervention by adapted physical education teachers or therapists.

Characteristics:

Inability or difficulty performing age-appropriate gross motor activities, e.g., head control, rolling, crawling, walking, running, jumping, hopping, skipping, throwing, catching, etc.

Inability or difficulty performing age-appropriate fine motor tasks, e.g., eating, holding a pencil or crayon, drawing or writing, etc.

Inability or difficulty performing expected daily living tasks, e.g., eating, dressing, toileting, etc.

Inability or difficulty performing expected class work, being unable to learn certain tasks or learning them very slowly using regular teaching methods. The child may seem disorganized or be inflexible when changes are necessary, distractable or slow to respond, have difficulty with positional concepts (reversals beyond age 7 or 8), be very active or lethargic, or may have difficulty forming letters or numbers.

4. Inservice topics related to identification:

Inservice on screening and referral procedures could help teachers become more cognizant of children with undetected motor problems. Administrators are encouraged to use adapted physical education teachers and therapists as inservice providers on such topics as:

a. Screening aids
b. Referral appropriateness
c. Behavioral expectations

B. ASSESSMENT

Assessment refers to the process of determining the need for, nature of and estimated time to be spent in therapy or instruction. It may also include the determination of coordination with other persons involved in the education of the child and the documentation that an assessment has been conducted. Assessment reveals the functional strengths and weaknesses and the effect of those strengths and weaknesses on the child's educational performance.

Assessment involves obtaining and interpreting data necessary for therapy or instruction. These data may be gathered through record reviews, specific observations, interviews, the use of standardized tests, performance checklists and other data collection procedures. The child's performance must be carefully documented and the information made available in report form to the staffing committee where a child's eligibility for special education placement is to be determined. If it is recommended by the assessor that adapted physical education and/or therapist's services are to be provided, then that assessor should be present at the staffing. If that is not possible, then someone capable of interpreting the results of the assessment and the report should be present.

The assessment may be in a group setting or conducted on an individual basis and in a structured or unstructured situation. Generally, the assessment would take place at school; however, certain activities of daily living might be better assessed in other environments. The assessment is designed to determine the child's present levels of functioning, what may be preventing him or her from functioning adequately, and what might be done to assist the child to improve his or her functioning ability. What will actually be assessed will vary with the needs of the child as seen by the referral conference committee, and the availability of other school personnel to perform the assessments required in their areas of expertise. Other personnel who may be able to assess the child's abilities are classroom teachers of the handicapped and educational diagnosticians. The adapted physical education teacher and occupational and physical therapists should be called upon to perform an assessment when the severity of the condition is beyond the classroom teacher's assessment expertise and/or training. While engaged in the process of assessment it is important that the assessor be attentive to such behaviors as: distractibility, difficulty in following directions, frustrations, etc.

1. *ADAPTED PHYSICAL EDUCATION* -- Areas of Assessment

   a. Activities of daily living

      1. Opening lockers
      2. Dressing for physical education

   b. Perceptual-motor abilities

      1. Motor planning
      2. Sequential motor patterns
      3. Motor memory
      4. Dominance
      5. Crossing the midline
      6. Body awareness

   c. Gross motor skills

      1. Locomotor skills
      2. Balance
      3. Rhythmic skills
      4. Object control skills (i.e., sports equipment)
      5. Physical fitness
      6. Posture

   d. Environmental adaptations

      Assessment of need for adapted physical education equipment and alternative activity.

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2. *OCCUPATIONAL THERAPY* -- Areas of assessment

a. Gross motor abilities

1. Level of development, i.e., head control, sitting
2. Postural reflexes, i.e., primitive reflexes as they affect body movement, development of balance
3. Strength, endurance and flexibility
4. Coordination, i.e., bilateral, reciprocal
5. Muscle tone, i.e., floppy, rigid
6. Joint range of motion and stability

b. Fine motor abilities

1. Level of development, i.e., grasp, release and manipulation of objects: pencils, scissors
2. Eye-hand coordination
3. Sensation, i.e., touch, pain, temperature
4. Dexterity and speed
5. Bilateral hand movements

c. Perceptual motor abilities

1. Sensory awareness, i.e., touch, joint and muscle input and balance information
2. Level of development of visual motor perception, integration and performance, i.e., shape and form, figure ground, writing and drawing
3. Spatial concepts, i.e., position in space and spatial relations
4. Planning movement
5. Body awareness
6. Laterality and directionality, i.e., right-left discrimination

d. Activities of daily living

1. Dressing
2. Feeding/eating/oral assessment
3. Hygiene/toileting/grooming
4. Functional ambulation and transfer
5. Preparation for home, school and prevocational skills

e. Needs for individual and environmental adaptation

1. Need , use and care of orthotic and prosthetic devices, particularly upper extremity
2. Presence of environmental constraints in classroom, etc.

2. e. (continued)

3. Need for individual adaptive equipment, i.e., eating utensils, dressing aids
4. Need for adapting existing equipment, i.e., desks, chairs, wheelchairs
5. Need for environmental adaptations, i.e., faucets, handles, kitchen adaptations
6. Need for adapting methods, i.e., handling and positioning, dressing, homemakin

3. *PHYSICAL THERAPY* -- Areas of assessment

a. Activities of daily living

1. Wheelchair skills
2. Wheelchair transfers
3. Ambulation with or without adapted equipment

b. Perceptual-motor abilities

1. Body awareness
2. Spatial orientation
3. Motor planning

c. Gross motor abilities

1. Postural reflexes
2. Level of motor development, e.g., head control, sitting balance, standing balance, etc.
3. Muscle tone
4. Muscular strength and endurance
5. Joint stability and range of motion
6. Posture
7. Gait and locomotor skills
8. General coordination responses

d. Fine motor skills

Fine motor skills required to participate in classroom activities should be observed in relation to physical maintenance.

e. Needs for individual and environmental adaptations

The activities of daily living assessment should be coordinated with an analysis of the child's orthotic/prosthetic and adapted equipment situation. This includes both an examination of the devices currently

3. e. (continued)

being used by the child and a determination of the child's needs particularly as related to the school environment.

Typical equipment to check:

1. Braces
2. Leg prostheses
3. Wheelchairs
4. Walkers
5. Crutches
6. Special chairs
7. Prone boards

f. Associated physiological conditions

The physical therapist is responsible for including observations of several physiological conditions in children, especially those with physical handicaps, both at the time of the original assessment and on a continuing, regular basis. These include the breakdown of skin areas due to pressure from braces or sitting positions, sensory disturbances such as loss of sensation in the extremities, circulation problems, respiratory functions, edema and bowel and bladder problems.

C. IEP DEVELOPMENT

Following comprehensive assessment of a child, the next steps involve determining the student's eligibility for special education services, designing an individualized education program (IEP) and placement of the pupil in the least restrictive environment. If the adapted physical education teacher/occupational therapist/physical therapist participated in the assessment of the child, he/she should also have a role in the determination of eligibility for special services. Since it may not always be possible for the adapted physical education teacher/occupational therapist/physical therapist to be present at the meetings, a written report may suffice. Good educational practice suggests, however, that the adapted physical education teacher and/or therapist be present. This is especially true if assessment warrants service provision.

The adapted physical education teacher/occupational therapist/physical therapist should provide information describing the assessment procedures used, the results and the recommendations related to eligibility for services and recommendations for possible adapted physical education/occupational therapy/physical therapy involvement. If possible, adapted physical education/occupational therapy/physical therapy results could be related to or discussed with the parents prior to presentation to the committee in order to assure the parents' active participation and awareness of the available alternatives.

In the process of determination of handicap, the adapted physical education teacher/occupational therapist/physical therapist may provide a service to the other team members by indicating ways in which the particular handicapping conditions may affect test results and interpretations, e.g., the need for appropriate positioning of a cerebral palsied child and/or the need for increased amounts of time to allow valid child responses to occur. Once a child has been determined handicapped, the next step is development of an IEP.

When it is the opinion of the staffing committee that adapted physical education and/or therapy services are needed, these services should be documented on the IEP. During the meeting, the adapted physical education teacher/occupational therapist/physical therapist can provide essential expertise to other team members to ensure that provision of all educational services takes into account the student's unique physical and behavioral needs.

The adapted physical education teacher should assist in the writing of the IEP. The occupational therapist or physical therapist may assist in writing separate parts of the IEP for the occupational therapy/physical therapy functions to assure integration of occupational therapy/physical therapy services with comprehensive goals and objectives being developed by other team members. If adapted physical education/occupational therapy/physical therapy services are not to be provided, documentation of the IEP team's decision should be included in the report; this information should be included in the student's file to document that consideration was given to provision of these services.

D. IMPLEMENTATION OF THE IEP

Some children, because of the nature of their handicaps, will require direct service. Once effective methods are determined, the adapted physical education teacher/occupational therapist/physical therapist should

train others to incorporate these techniques into the child's educational experience. Other children will be most effectively served through consultation with the adapted physical education teacher/ occupational therapist/physical therapist incorporating suggested techniques for an individual child into an IEP which will then be implemented by other school staff and parents.

A delineation of services, direct and consultative, which can be provided by adapted physical education, occupational therapy and physical therapy follows. Given the legal mandate to provide related services only if such services are essential for the provision of an appropriate education, an educational rationale must be provided for the direct services of occupational therapy and physical therapy.

Direct services may be provided using a multi- or interdisciplinary educational approach to individuals and small groups within or outside the classroom. While providing these services, the therapist or adapted physical education teacher coordinates activities with other professionals, parents, and individuals in public or private agencies who are working with the child. This may involve training parents, professionals or paraprofessionals to carry out a specific program and monitoring that program by working directly with the child, parent, professional or paraprofessional.

In the consultation role, the therapist/adapted physical education teacher is one member of an interdisciplinary education team who collaborates with a variety of personnel to assist students with special needs. Consultation with others working with the child is vital for optimum results. This must be done within the framework of coordinating therapy and adapted physical education services in relation to the overall philosophy and direction of the educational program.

As with assessment, services by an occupational or physical therapist and an adapted physical education teacher are provided only when the severity of the condition places the educational problem outside the training and expertise of the classroom teacher. The determination that services are required is made by the staffing committee. Termination of services may occur at any time the IEP is in effect and is also a decision reached by the staffing committee.

1. *ADAPTED PHYSICAL EDUCATION SERVICES*

    a. Direct services

        1. Physical fitness

            --muscle strength
            --endurance
            --flexibility
            --weight maintenance

2. Balance

   --static balance
   --dynamic balance

3. Perceptual-motor skills

   --visual fixation and tracking
   --eye-hand coordination
   --eye-foot coordination
   --motor planning, sequential motor patterns, and
     motor memory

4. Locomotor skills

   --running
   --leaping
   --jumping
   --hopping
   --galloping
   --sliding
   --skipping

5. Posture

6. Body awareness

   --ability to identify body parts
   --ability to imitate movements
   --spatial orientation
   --midline crossing
   --determination of dominance

7. Body control

   --relaxation skills
   --body control throughout movements

8. Coordination

   --rhythmic coordination
   --integration of body movements

9. Play skills

   --ability to use and care for equipment
   --ability to comply with rules
   --ability to share equipment
   --ability to compete in activities
   --ability to engage in cooperative play

SECTION II:
Delivering
Services

10. Behavior

--self-motivation
--ability to attend to task
--ability to persevere in task
--development and improvement of appropriate responses

11. Object control skills

--kicking
--throwing
--rolling
--catching
--bouncing
--striking

12. Activities including all sports and games appropriate for disability of child and sports knowledge to be an informed spectator.

b. Consultative services

1. General

--help organize special education classes or integration into the regular class
--suggest materials, equipment and activities
--provide resource materials
--give instructions and information on available testing devices
--offer expertise in developmental sequencing and age expectations
--provide information on disabling conditions and help assess skill level
--provide information on the adapted physical education program to school administrators, parents, and teachers
--consult with support service members (e.g., occupational therapists, physical therapists, social workers, nurses, psychologists) regarding the child's specific needs in order to determine implications for physical education programming
--coordinate program information with community recreation agencies, college and university adapted physical education programs and special events, such as Special Olympics, Rocky Mountain Games
--provide inservice programs

2. Specific

--provide assistance in adaptation of equipment for special needs
--suggest behavior management techniques in physical education situations
--assist in establishment of realistic goals and objectives for each child
--provide necessary information for staffing and school screenings
--report to parents: level of performance, progress reports and suggestions for supplemental activities

2. *OCCUPATIONAL THERAPY SERVICES*

a. Direct services

1. Gross motor abilities

Planning and providing treatment toward improvement in gross motor performance, such as using neuromusculature facilitation and other techniques to increase range of stiff joints, increase muscle strength and endurance, improve motor coordination and decrease ineffective movement patterns. These services enhance the child's motor skills, enabling the child to participate to his/her highest capacity in the classroom, playground, home and community. For example, the child may be able to hold a more effective sitting position or get around the classroom more easily.

2. Fine motor abilities

Developing fine motor abilities such as reach, grasp, eye-hand coordination and dexterity. This treatment can lead to more effective performance in such activities as eating, holding a pencil for writing or drawing, art activities, play/leisure and job-related skills.

3. Perceptual motor abilities

Working directly with a child to improve sensory processing such as balance and movement information, joint and muscle input, visual awareness, touch and pressure; to improve body image, spatial concepts, underlying postural abilities for skill and movement mastery, and to assist in bridging the gap between underlying abilities and skill acquisition.

4. Activities of daily living

   Working directly with the child or youth to teach self-care and other daily living activities (e.g., feeding, dressing, toileting, basic homemaking, preparation for vocational skills).

5. Activity-related social/emotional responses

   Using goal-directed activities to increase attention span and tolerance for frustration, to channel emotional expression, reduce hyperactivity, improve social interactions, and increase self-esteem. For example, enabling a physically handicapped child to function more independently in eating may improve his/her self-esteem; improving a child's sensory processing may reduce his/her hyperactivity.

6. Needs for individual and environmental adaptation

   Obtaining or seeking resources for special equipment or adapting existing equipment, methods, or the physical environment to help the child function more independently.

b. Consultative Services

1. Consulting with classroom teachers or others involved with children in relation to program planning, adapting the physical environment, or modifying curricular procedures for specific problems when appropriate and on an ongoing basis.

2. Communicating with other professionals working with the child (e.g., speech therapist, physical therapist, physical education teacher, psychologist, etc.) in order to coordinate the child's program on an ongoing basis.

3. Making home visits, meeting with, training and supervising the parents as needed to help coordinate the child's therapy program with home activities (e.g., handling, living skills, play).

4. Training and supervising paraprofessionals, volunteers, or other individuals in order to provide an extension of occupational therapy services.

5. Providing inservice training for those involved with handicapped children to increase their understanding and abilities to meet the children's needs.

6. Determining need for and receiving supervision/ consultation from other staff or outside agencies.

7. Communicating with physicians and community agencies as needed to provide optimum occupational therapy services to the child.

3. *PHYSICAL THERAPY SERVICES*

The primary goal of direct physical therapy services and consultation in special education programs is to enable the handicapped child to achieve maximum independence for functioning in the school environment.

Treatment is the management of disability based upon the results of the evaluation. It is initiated following the diagnosis and recommendations from the child's physician and may include, but not be limited to:

a. Direct services

1. Gross motor abilities

--neurodevelopmental and neuromuscular facilitation techniques to improve level of developmental capabilities, e.g., sitting to crawling, crawling to ambulation
--joint mobility/stability procedures for increasing speed, accuracy and strength in abilities to effectively permit the child to participate in daily school activities
--strengthening of muscular systems to increase endurance and tolerance for daily activities
--range of motion activities to prevent contractures which might interfere with use of extremeties in school tasks
--postural control and improvement, e.g., scoliosis exercises

2. Fine motor abilities

--treatment to improve functional use of hands for manipulating adaptive equipment, e.g., lock and unlock braces and crutch use

3. Perceptual motor abilities

--therapeutic intervention designed to enhance the child's awareness of his body, his relationship to other objects and to improve his ability to successfully negotiate in his educational environment

4. Respiratory function

--strengthening of respiratory systems to increase endurance and tolerance to attend school a full day
--postural drainage

5. Associated physiological conditions

--monitoring problems associated with sensory deficits
--management of skin care, e.g., related to pressure from braces or sitting positions
--instruction in bowel and bladder management following the physician's directions and in cooperation with the school nurse, classroom aide, child and parents

6. Needs for individual and environmental adaptations

--monitoring of prosthetic, orthotic and adaptive equipment
--positioning in order to maintain child in best position for learning, including proper chair and table heights
--transfer skills to permit the child to manage in his or her environment with minimal assistance
--ambulation training to obtain maximum mobility with the environment
--adaptation of environment for accessibility to wheelchairs and other special needs

7. Activities of daily living

--working with the child to improve the skills needed on a day-to-day basis in the school, on the bus or at home

b. Consultative services

1. General consultative services

--suggestions for the elimination of environmental constraints

--advisory capacity regarding special equipment
--long-range planning for management of the handicapped child in the school setting
--serving as a liaison between school and medical community

2. Specific consultative services

--explaining physical abilities and disabilities
--explaining the rationale for physical therapy intervention
--teaching special skills for proper handling and positioning of children
--recommendations for the prevention of contracture, deformity, fracture, skin problems, etc.
--demonstrating use of adaptive and assistive devices
--demonstrating the use and care of supportive bracing
--safety considerations and techniques for staff and children
--consultation regarding specific activities for specific children in regular and adapted physical education

E. REASSESSMENT

Reassessment relates to two processes which are integral parts of the provision of services to handicapped students. An annual (at minimum) review of the IEP is required by state and federal statute. A triennial reassessment to determine eligibility for services is likewise required. As members of the educational staff, adapted physical education teachers should be integrally involved in both processes. When occupational therapists/physical therapists are involved in programming, they, too, should be involved in the reassessment.

Depending on the scope of involvement by the adapted physical education teacher/occupational therapist/physical therapist in the child's program, a detailed assessment may be necessary on an annual basis for children receiving these direct services. Furthermore, such assessment must be conducted as a part of the triennial evaluation (if an assessment was conducted as a part of the initial placement and if services are still being applied). In addition, formal assessment should be completed when requested by parents or physicians concerned with the treatment of the child.

When formal assessments are not conducted as part of the annual IEP evaluation, the adapted physical education teacher/occupational therapist/physical therapist should provide recommendations regarding revisions in the IEP in the following areas:

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1. Goals and objectives
2. Types of personnel for implementation
3. Types of environments utilized

Again, all written reports become part of the child's confidential files. Such reports should be shared with the physicians concerned with the treatment of the child (with the parents' signed permission) and with the parent. Adapted physical education teachers/occupational therapists/physical therapists should sign any IEP revision documents in which they had a part.

SECTION III: Monitoring Services

A. ADMINISTRATIVE MONITORING

(This part is adapted from "Guidelines for Occupational and Physical Therapy Services in the Public Schools of Virginia" 1978.)

The administrator must take care to assure that adapted physical education/occupational therapy/physical therapy services are delivered appropriately. She/he should monitor the services and conduct formative evaluation to determine the need for changes in concepts regarding services being delivered, organizational structures, staffing and resources, and procedures for management of records. Periodically, a summative evaluation should take a broad look at the impact of the program. As with other school division personnel, the individual adapted physical education teacher/occupational therapist/physical therapist must be evaluated. Both formative and summative program evaluation procedures are described below:

Formative Evaluation

The administrator should obtain reports from personnel involved with adapted physical education/occupational therapy/physical therapy services on an ongoing basis. These could be either verbal reports provided in meetings or written reports submitted, for example, monthly. The intent of these reports would be to determine the adequacy of the original design for the delivery of services. The following questions might be asked:

1. To what extent is the organizational structure working?

   --Are adapted physical education teachers/occupational therapists/physical therapists adequately supervised by school personnel?
   --Are adapted physical education teachers/occupational therapists/physical therapists adequately communicating with medical personnel?
   --Are lines of communication open?

2. Are there adequate adapted physical education/occupational therapy/physical therapy staff and resources?

   --Are the service models (i.e., center-based, itinerant) and case loads appropriate?
   --Are adapted physical education teachers/occupational therapists/physical therapists provided with sufficient materials and equipment?

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--Are adapted physical education teachers/occupational therapists/physical therapists provided with adequate facilities?
--Are other necessary resources provided (office, secretarial support, inservice, travel support)?

3. Are adapted physical education/occupational therapy/physical therapy records being managed appropriately?

--Are procedural safeguards in place?
--Do adapted physical education teachers/occupational therapists/physical therapists have appropriate access to records?
--Are adapted physical education teachers/occupational therapists/physical therapists documenting and keeping appropriate records?
--Are relationships with physicians documented?

4. To what extent are adapted physical education teachers/occupational therapists/physical therapists providing unique services?

--To what extent do direct services overlap with other direct service providers?
--To what extent are consultative services integrated with inservice?

Results from asking these types of questions at an administrative level should provide for refining the delivery of adapted physical education/occupational therapy/physical therapy services. The administrator may wish to use the contents of these guidelines as standards for judging the quality of these services.

Summative Evaluation

On a periodic basis, the local administrative unit should have a third-party review of adapted physical education/occupational therapy/physical therapy services. In the initial years of implementation, it may be preferable to conduct a summative evaluation of this type each year. As the program matures, however, such an evaluation may not be necessary more than every three to five years. It is recommended that the primary evaluator(s) be a person or a team of persons having the expertise and training to judge the quality of adapted physical education/occupational therapy/physical therapy services. Administrators may wish to use a consultant from one of these disciplines to assist in designing the evaluation process and in helping conduct the third-party evaluation. It is further recommended that the adapted physical education, occupational therapy, and physical therapy personnel in the local administrative unit participate in setting the goals and objectives to be evaluated.

B. PROFESSIONAL MONITORING

Adapted physical education teachers, occupational therapists and physical therapists should systematically review their performance. This can include both self-evaluation and peer review and should focus on the quality and outcomes of their direct and consultative services, their relationships both within and outside their disciplines as they affect their performance, and the appropriateness and quality of their management and administrative functions. If deficits are found, a plan should be made, implemented, and evaluated with the aim of correcting these deficits.

Adapted physical education teachers, occupational therapists, and physical therapists should provide appropriate management and administrative services. Management and administrative functions may include:

1. Reviewing periodically all aspects of the total program to determine effectiveness and efficiency
2. Maintaining current certification as required by state regulations
3. Maintaining current records/files/charts to meet school requirements and professional standards
4. Participating in budget planning, ordering of supplies, maintaining budget expenditures and the inventory of supplies and equipment
5. Attending and participating in conferences and committee meetings related to school programs
6. Having a knowledge of and utilizing community resources
7. Providing orientation of staff, volunteers and visitors to adapted physical education, occupational therapy and physical therapy services
8. Cleaning, preparing environment and equipment
9. Reading related files
10. Traveling from school to school
11. Planning and scheduling services and programs
12. Understanding and monitoring self relative to discipline's standards of ethics

In the supervisory role the professional receives and/or provides supervision regarding the services. The functions related to supervision include:

1. Providing informal and formal training of personnel and assigned volunteers
2. Maintaining awareness of and seeking out appropriate guidance and consultation
3. Reviewing performances (of self and others) and providing evaluations

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C. ON-SITE MONITORING BY COLORADO DEPARTMENT OF EDUCATION (CDE)

CDE, during scheduled on-site visitations, can provide assistance through the on-site team to the local administrators and the practicing professionals in monitoring the services of the professional.

Epilogue

It is hoped that this document clarifies the interrelationships of these three disciplines as they relate to provision of full services to handicapped children. As mentioned in the introduction, this effort was designed as a beginning. Several strategies could be employed to further clarify adapted physical education, occupational therapy and physical therapy services. These include:

1. Development of model forms for all three services
2. Development of interagency agreements
3. Revision of Type E certification requirements
4. Ongoing inservice for adapted physical education teachers, occupational and physical therapists to maintain certification (e.g., continuing education, outreach, workshops, etc.)